STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Maltreatment Determination and Disqualification of Eric W. Nelson

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION

The above-entitled matter came on for hearing before Administrative Law Judge Barbara L. Neilson on August 12 and 13, 2003, at the Office of Administrative Hearings in Minneapolis, Minnesota. The OAH record remained open until September 15, 2003, for receipt of the parties' post-hearing submissions.

Michael E. Burns, Assistant Attorney General, 445 Minnesota Street, Suite 900, St. Paul, Minnesota 55101-2127, appeared on behalf of the Department of Human Services. George L. May, Attorney at Law, May & O'Brien Law Offices, 204 Sibley Street, Suite 202, Hastings, Minnesota 55033, appeared on behalf of the Respondent, Eric W. Nelson.

THESE FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATIONS ARE PUBLIC, BUT THE HEARING RECORD ON WHICH THEY ARE BASED CONTAINS INFORMATION THAT IS NOT PUBLIC.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Minnesota Department of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions, and Recommendations that appear in this Report. Pursuant to Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until after the parties have had access to this Report for at least ten days. During that time, the Commissioner must give any parties adversely affected by this Report an opportunity to file objections to the Report and to present argument supporting their positions. Parties should contact the Office of the Commissioner of Human Services, 444 Lafayette Road, St. Paul, Minnesota 55155, telephone (651) 296-3971, to find out how to file exceptions or present argument.

The record of this contested case proceeding closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes. If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision, under Minn. Stat. § 14.62, subd. 2a.

STATEMENT OF ISSUES

The issues presented in this contested case proceeding are: (1) whether the Department correctly determined that the Respondent committed two acts of maltreatment of a vulnerable adult; (2) if so, whether the Department properly disqualified the Respondent from a position allowing direct contact with persons receiving services from programs licensed by the Department of Human Services and the Department of Health, from facilities serving children or youth licensed by the Department of Corrections, and from unlicensed Personal Care Provider Organizations; and (3) if the disqualification was correct, whether the Respondent presents a risk of harm to the health and safety of the clients he wishes to serve.

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Respondent, Eric W. Nelson, is a 35-year-old man who has worked in residential facilities for vulnerable adults since approximately 1990. The Respondent graduated from high school in 1986, attended college for 1½ years, and attended a three-month training course in human services. His employment has included working in the Faribault Regional Treatment Center caring for the mildly through profoundly mentally retarded, working in intermediate care facilities for the mentally retarded, working as a job coach at a day training site, and working as a direct care provider for State Operated Community Services ("SOCS").[1]

2. During his years of working with vulnerable adults, the Respondent has assisted several vulnerable adults who were physically aggressive at times and has had to employ therapeutic intervention techniques and controlled procedures. The Respondent has been trained in therapeutic intervention and has received training and periodic updates regarding vulnerable adult laws.[2] Therapeutic intervention involves procedures to assist persons with developmental disabilities when they are engaging in aggressive and assaultive behavior. These techniques include attempts to talk to the individual, coax him with a non-physical device, and verbally redirect him before using physical intervention. It is, however, sometimes necessary to employ physical assistance if oral persuasion does not work. Physical interventions are to be as nonobtrusive as possible. One example of such a physical intervention would be application of a basket hold, which immobilizes the individual's upper body until he or she calms down.[3]

3. At the time of the allegations involved in this case, the Respondent worked as a Human Services Technician in an adult group home that is a DHS-licensed foster care located on Crystal Lake Road in Burnsville, Minnesota. The focus of the Human Services Technician job is to work directly with clients in implementing their plans and give supports where necessary regarding activities of daily living. The goal is to make clients as self-sufficient as possible and help them develop skills so they don't need as much assistance.[4] The Burnsville group home is located in a single family home in a residential area. Four people reside there. All four are developmentally disabled (profoundly retarded) and also have psychiatric diagnoses. The Respondent and the other staff members provided assistance to all four residents. Their duties included

cleaning, cooking, giving out medications, bathing, dental care, and otherwise taking care of the residents' needs.[5]

4. At the time the Respondent was employed at the Burnsville group home, approximately eight staff people were employed at the site. Generally, two persons were employed per shift except for the overnight shift, when only one was employed. During January and February of 2002, there were periods when the group home was short-staffed since there was a lot of turnover. Typically only one staff person was assigned to the 1:00 to 11:00 p.m. shift. During the month of February, 2002, the Respondent worked alone on the afternoon shift on a fairly frequent basis.[6]

5. M.R. is a 51-year-old male who has resided in the Burnsville group home since 1995. He lived in the Faribault Regional Treatment Center prior to that time. M.R. is approximately 5'3" or 5'4" tall and weighs approximately 130-140 pounds.[7] He is profoundly mentally retarded with an adaptive behavior age equivalent to an eighteen-month-old. He is not able to speak but is able to make sounds and can indicate preferences through gestures and physical displays. M.R. has moderate to severe hearing loss in his left ear and severe to profound hearing loss in his right ear. He has a history of osteomyelitis with a question of Pagets Disease of the bone with a long history of fractures. He has a rod in his right leg which affects his balance and mobility. He is capable of walking but does so with a limp and with difficulty. He does not react safely to such hazards as icy sidewalks. M.R.'s target behaviors include aggression towards others (hitting, kicking, slapping, pushing, grabbing and/or throwing objects towards others), real or attempted property destruction (flipping furniture, slamming doors, throwing or breaking objects, punching or kicking holes in walls or windows), and tantrum behavior (outbursts of screaming, hooting loudly, stripping, running, flinging clothes or spitting).[8]

6. During weekdays, M.R. was transported back and forth from the group home to a day training and rehabilitation program operated by Chrestomathy, Inc., in a 15- to 18-passenger van like the one pictured in Exhibits 16-19. Chrestomathy, Inc., is a privately owned and operated program that serves persons with developmental disabilities and specializes in persons with severe developmental disabilities or behavioral problems. Chrestomathy has a very difficult clientele because it works with behaviorally-challenged individuals.[9]

7. M.R. sat at a table by himself when he went to Chrestomathy because he would sometimes be aggressive. He has torn out some people's hair when they got too close to him.[10] He exhibited target behaviors 50 to 60 percent of the time when he was at Chrestomathy. According to one Chrestomathy staff member, M.R. was the most physically difficult client she had at Chrestomathy.[11]

8. The Human Service Technicians and nurse working at the Burnsville group home and their supervisor have voiced some dissatisfaction with the Chrestomathy day program. Burnsville group home staff noted on numerous occasions that their clients came home from Chrestomathy dirty with food dried on their faces, wearing soiled adult diapers and dirty clothing. M.R. also sustained numerous injuries while at Chrestomathy. The Respondent called Chrestomathy's Program Director regarding lunch boxes of clients coming home dirty with communication books inside rather than

in outside pockets.[12] Two other Human Services Technicians employed at the Burnsville group home (Lori Schulz and Tammy Kotek) have called the Chrestomathy Program Director on several occasions to voice complaints and have noticed a high level of employee turnover at Chrestomathy.[13] On one occasion, the Respondent went to Chrestomathy to pick up a different client and found M.R. sitting in the hallway unsupervised with his back against the wall, doing nothing.[14] The Respondent's supervisor, Jane Richert, was aware of complaints that it was difficult to get M.R. to leave the Chrestomathy van, allegations that the drivers were rude and the drivers and assistants were not receptive, and allegations that Chrestomathy did not employ behavior modification approaches with M.R. Ms. Richert talked to Chrestomathy informally and called with any legitimate concerns that the group home staff told her they had.[15] M.R.'s mother and sister have also been dissatisfied with Chrestomathy. M.R.'s sister was informed that M.R. ate a plastic bag containing food sent from his home while at Chrestomathy one day and felt that Chrestomathy should have placed food on M.R.'s plate rather than giving him access to the bag.[16] M.R.'s mother has not been satisfied with M.R.'s care and progress while he has attended Chrestomathy, has found him sitting in the hallway by himself while at Chrestomathy, and believes that he is neglected at times.[17]

9. M.R. often becomes agitated and/or physically aggressive during van rides. During his van rides, M.R. spits, yells, hits the seat and himself, bites himself, strips his clothes off, throws his clothes at the driver, and bangs on windows. He often disrobes and refuses to get out of the van when it arrives at its destination. Thus, he was subject to tantrums and acting out when he was transported back and forth from the group home to Chrestomathy.[18] M.R. has attacked Chrestomathy staff during van rides. He has scratched, hit, kicked, and grabbed a Chrestomathy employee while on the van, and also has pulled her hair and ripped her shirt.[19] M.R. also has attacked peers on the van.[20] Group home staff was told that they would have to physically intervene at times with respect to M.R.'s behavior during van rides.[21]

10. The Consumer Support Plan developed for M.R. describes difficulties with his behaviors and is designed to teach alternative strategies to decrease certain target behaviors by employing behavior modification principles. Based upon assessments done of M.R., his County case manager and others on his team have developed an Individual Service Plan which summarizes his skills in various areas and describes his IQ, functioning, and goals. The Human Service Technicians who work directly with clients in SOCS are made aware of these plans, which are updated annually or more often. The Human Service Technicians are responsible for reading the plans in full and reading them regularly thereafter. The Respondent initialed to show that he had completed a checklist of items regarding M.R. and his orientation. By initialing, the Respondent showed that he knew of M.R.'s behavioral goals.[22]

11. M.R.'s Consumer Support Plan notes the following under Transportation Procedure:

> When [M.R.] is making the transition back and forth between his home and work with a group of people, especially when a vehicle is used, this results in a confined and crowded situation which seems very stressful for M.R. and causes numerous problems such as temper outbursts, stripping and aggression. Caution should be taken to create environments and

> situations which avoid these stressful circumstances and minimize the possibility of behavior problems. [M.R.'s] work site has a formal program for [M.R.] to learn appropriate behaviors while riding to and from work. At times, work staff may need home staff assistance to carry out this problem. Emphasis will be on taking a consistent approach so that [M.R.] learns to safely use work transportation without drawing negative attention to himself. . . . If [M.R.] starts to exhibit target behaviors during transportation, staff must redirect and intervene to protect others from harm. The outing will be terminated as soon as possible. Outings that are optional and easily terminated will be set up in the residence several times a week, so an immediate response to his aggression can be implemented. When aggression occurs[,] come in house[,] leave doors open for him to get off van and come in on his own.[23]

12. M.R.'s Individual Service Plan indicates that M.R. "typically displays non-compliant or resistive behavior, frequent disrobing, and temper tantrums, as well as some aggression such as hitting and kicking, and self-injurious behavior such as slapping his arms."[24] M.R. is aggressive to the point of being almost assaultive, and kicks and hits group home staff. It also is common behavior for M.R. to strike his own forehead with his fist or bang his head against a wall. He has numerous scars on his head reflecting old injuries from when he resided in the Faribault Treatment Center. Sometimes his self-injurious behavior does not leave a mark, however. Because he shows a high potential for self injury, bruises and abrasions are not unusual. [25]

13. M.R.'s behavior and moods can vary dramatically from minute to minute. He can seem fine one minute and intentionally bang his head the next. M.R. usually required more care than the other three residents in the Burnsville group home.[26] M.R. generally likes group home staff. However, if he can't get their attention right away, it can result in a display of his target behaviors, such as property destruction, tantrums, and aggression.[27] M.R. will comply for certain people with whom he has a rapport. It is harder for him to take directives from women.[28]

14. M.R. engaged in many target behaviors and often won't respond to verbal requests to stop. If staff needs the behavior to stop, they may need to go to the next step by providing physical assistance. If M.R. is in danger, then he should be moved to get him out of danger. At times M.R. becomes aggressive and there needs to be physical intervention. M.R. typically reacts to physical intervention by displaying more intense behavior and becoming more resistant and more agitated. If he is held, it sometimes makes his behavior worse. As a result, it was suggested that staff approach M.R. in a calmer manner and physically intervene only when all else failed. It was sometimes best to observe but not intervene to avoid making his behaviors more intense and having him become physically aggressive.[29]

15. A variety of methods are used to relax M.R. and gain his cooperation when he is agitated or aggressive. If he is not in danger of injuring himself or others and is not engaged in significant destruction of property, the preferred method of handling him is to simply let the behavior continue until he stops on his own. With respect to getting him to leave the van, a common recommended procedure is to simply ignore him until he decides to get out on his own, as long as there are no safety concerns.[30]

16. When M.R. is agitated and exhibiting target behaviors, Burnsville group home staff are told to assure that others are out of harm's way and try to redirect or distract M.R. They are supposed to protect M.R. from self injury and keep him and other vulnerable adults around him safe. They may get M.R. to go to another area by redirecting him or assisting him to an area where he can calm down.[31] If that doesn't work, they are just supposed to let him go as long as he is not hurting others or himself.[32] Although the staff must attend to M.R. when he is in the throes of a display, they are supposed to intervene without giving M.R. too much attention, and are also supposed to reinforce M.R.'s behavior when he is being appropriate.[33]

17. The Chrestomathy employees had the responsibility to bring M.R. home from the day program, get him off the van, and bring him to the front door of the house.[34] Some Burnsville staff members would simply wait inside the house for M.R. to get off the Chrestomathy van and leave it up to Chrestomathy staff to handle situations in which M.R. refused to leave the van. For example, Ms. Schulz would leave the door to the house open and Chrestomathy would leave the van door open so that M.R. could come in when he wanted to.[35] Ms. Kotek would go out and say "hi" to M.R. to let him know she was there. Chrestomathy staff usually sat and waited for him to decide when he was ready to leave the van, and kept the van door open to encourage him to come out. Ms. Kotek found that M.R. was capable of getting out and coming to the door on his own.[36]

18. However, the Respondent's normal practice when the Chrestomathy van pulled in was to either be in the garage or out by the front door. He believed that the Chrestomathy employees did not employ the proper procedures to encourage M.R. to get dressed and leave the van and he typically went outside to assist in the process.[37] In the Respondent's experience, Chrestomathy staff never got out of the van at the end of the day, and group home staff had to go outside every day to get their clients. Burnsville group home staff gave advice to Chrestomathy staff but, in the Respondent's opinion, they would not follow it. He believed that Chrestomathy staff were not sufficiently trained to deal with the clients they were transporting. Even if he was outside in the garage of the Burnsville group home, Chrestomathy staff would not get out and open the van doors. On one occasion while standing in the garage, the Respondent remarked to another staff member, "Look at those fools. They can't even get out of the van. They don't even see us standing here."[38]

19. On February 18, 2002, Lisa Volk and Judith Harper, both of whom were employed by Chrestomathy as Program Trainers, transported M.R. back to the Burnsville group home following a day at their program. Ms. Volk had been working with Chrestomathy since the end of 1999, and Ms. Harper had been working with Chrestomathy only for a few months. Neither of them had been trained in therapeutic intervention, although they had had in-service training on various subjects, including vulnerable adults. They arrived at about 3:00 or 3:15 p.m. The Respondent was on duty inside the group home. It was a chilly winter day. M.R. had taken his shirt off before they pulled into the driveway and was bare-chested. He did not want to get off of the van. M.R. was the only client on the van that day and was seated in thethird or fourth row of benches of the van,[39]next to the window on the driver's side of the van. After the van stopped in the driveway of the group home, Ms. Harper and Ms. Volk

unfastened M.R.'s seatbelt. The Respondent walked calmly out to the van. The Respondent stood on the pavement outside the side door of the van, and Ms. Volk stood next to him on his right. The Respondent faced M.R. in the back of the van and held out his hand. M.R. slapped his hand in a "high five" greeting. The Respondent pulled his hand away and urged M.R. to come in the house. When M.R. did not comply with the verbal cues to leave the van, the Respondent placed one foot in the van, leaned into the van, and extended his left hand. M.R. reached out and grabbed the Respondent's extended hand. The Respondent pulled M.R. to a standing position and pulled him up against the back of the seat in front of him for approximately 30 to 60 seconds. Ms. Volk noticed that a vein in the Respondent's arm was protruding with the effort of pulling as he pulled M.R.and he had a stern look on his face. M.R. made a "hooting" type of noise in a loud and aggressive fashion. M.R. makes that noise when he is annoyed. M.R.'s feet went out from under him and he then fell onto the van floor on his bottom,off to one side a little bit. M.R. scooted on his backside on the floor of the van, got out, and walked to the house.[40]

20. On February 26, 2002, Chrestomathy employees Judith Harper and Sarah Reed, who was employed by Chrestomathy as a program trainer from October 2001 to June 2002, transported M.R. home in the Chrestomathy van.[41] There was not much snow, but there were patches of ice. During the ride to the Burnsville group home, M.R. was stripping, throwing shoes and clothing at the driver, and biting his thumb, which was typical behavior for him at the end of the day. By the time they were halfway home, M.R. had taken off all of his clothing and refused to put it back on. He was the only client in the van that day, and sat in the second row of bench seats on the driver's side, next to the window.[42] Ms. Reed tried to talk to him, calm him down, and give him his clothes back. By the time they arrived at the group home, M.R. was still noncompliant and not interested in putting his clothing on.[43]

21. The Respondent was the only staff member on duty in the group home on February 26 when the Chrestomathy van pulled into the driveway of the group home. One other resident was home at the time.[44] Ms. Reed opened the door of the van and got out. She tried to talk M.R. into putting on his clothes. M.R. was hooting and hitting the ceiling of the van. Ms. Reed entered the van and sat in the second bench seat, and Ms. Harper sat in the driver's seat. About one minute after the van arrived at the group home, the Respondent came out to the van. Ms. Reed handed M.R. his underwear and prompted him to put it back on. M.R. responded by throwing his underwear back at Ms. Reed. Chrestomathy usually carried a blanket, but they were using a different van than usual that day. Ms. Reed asked the Respondent for a blanket and he said that he didn't have one. He did not offer any other explanation. The Respondent then stepped into the van and verbally prompted M.R. to put his underwear on. When M.R. refused, the Respondent tried offering him a snack to gain compliance. Ms. Harper, Ms. Reed, and the Respondent all told M.R. that it was time to go and that he should put his clothing back on. M.R. continued hitting the top of the seat in front of him, biting his thumb, and bouncing in his seat. The Respondent remained calm with M.R. until M.R. hit him on the arm. The Respondent then got into the seat next to M.R. and loudly yelled at M.R. to put on his clothes. M.R. responded by yelling and getting more agitated, but did put on his underwear and pants. Ms. Reed and the Respondent got out of the van and waited about two minutes. They told M.R. it was time to get out of the van. The

Respondent then entered the van and sat on his knees in the seat in front of M.R., facing backward. He continued talking to him. They all urged M.R. to come out of the van. When M.R. did not comply, the Respondent took hold of M.R.'s right arm and pulled him across the bench seat to the side while yelling at him. When the Respondent released his arm, M.R. fell over on his side and hit his head on the side of the van door. Ms. Reed heard a loud thud when this happened. She did not see any contusion or bleeding. M.R. shouted over and over again when he hit his head on the side of the van door. Ms. Harper heard M.R. scream and saw his eyes well up with tears. Once M.R. was sitting on the floor in the doorway of the van, the Respondent reached in behind M.R., placed his arms under M.R.'s armpits, lifted him, and carried him out. The Respondent carried M.R. to the garage, and he walked from the garage into the house.[45]

22. A report regarding the incidents of February 18 and 26, 2002 was received by the Program Director of Chrestomathy. Chrestomathy's director and a supervisory employee conducted an internal investigation into the allegations of maltreatment, including interviewing the Chrestomathy employees who witnessed the incidents.

23. Chrestomathy's Program Director was not aware of any allegations made by the Respondent regarding Chrestomathy. He was not aware of any disagreements between the Respondent and Chrestomathy staff and he has no animosity toward the Respondent.[46]

24. The February 18 incident was reported to the County Common Entry Point on February 19, 2002, and faxed to DHS on the same day. The February 26 incident was reported to the County Common Entry Point on February 27, 2002, and the information was faxed to DHS on March 1, 2002. The matter was assigned to Mr. Galoway on March 4, 2002. His notes show that he received the case on March 7, 2002 and called the mother of M.R. that same day.[47]

25. Chrestomathy was supposed to have a blanket in the van to cover M.R., if necessary. They usually had a blanket, but did not have one on February 26, 2002. Occasionally, Chrestomathy asked the Burnsville group home staff for a blanket and they would provide one.[48] There are blankets in the group home that could have been provided.[49]

26. There is no evidence that M.R. suffered any bruising, swelling, or other medical injuries relating to either of the two incidents or that he was seen by a doctor in connection with these incidents.[50]

27. Both of the maltreatment allegations involving the Respondent were investigated at the same time by a DHS employee. The original DHS investigator worked for the Department from October 1, 2001, until April, 2002, and was not retained by the Department at the end of his probationary period for reasons unrelated to his investigations. At the time the original DHS investigator left his employment, his investigation was complete and he had prepared a draft investigative report. He had interviewed the Respondent, staff persons with Chrestomathy who were present in the van with M.R. during the incidents, and the Respondent's supervisor and co-worker at the group home. James Janecek, the Manager of the Investigations Unit of DHS Licensing Division and the original DHS investigator's supervisor, took over his case

load after he left the agency. Mr. Janecek had confidence in the original DHS investigator's investigation because he trained him, went on several investigations with him, and watched his methods. Mr. Janecek did not gather any investigative information or conduct any part of the investigation. Mr. Janecek reviewed the original DHS investigator's draft report, edited it, possibly reorganized some of the information, and passed the matter to Judy Nass, a senior investigator. The file contained interview information, facility internal review information, a history and background of the client, general policies of the facility, and information about training of employees. Ms. Nass reviewed the investigative file and compared the evidence in the file to a summary that had been written in draft form. Because she found the evidence in the file to be supported and sufficient for completion of the investigation, she did not obtain additional investigative information. She did not talk to the Respondent or the witnesses interviewed by the original DHS investigator. She did not observe the Chrestomathy van. Once the report was completed by Ms. Nass, Mr. Janecek conducted a final review. Ms. Nass made some final edits and issued and distributed the report. Ms. Nass did not talk to any of the witnesses.[51]

28. M.R.'s legal guardian made Ms. Richert aware of the allegations regarding the Respondent's treatment of M.R. approximately three weeks after the incident. She did not know of the allegations previously. She usually receives official notification if the report is delayed, but did not receive such notice here. The licensing case manager told Ms. Richert that a report had been received by the Dakota County Common Entry Point. Ms. Richert spoke to the Respondent based upon what she had heard from the guardian. The Respondent said that he did not use excessive force. Ms. Richert asked a social worker at the Common Entry Point whether she should begin an internal investigation, and was told that the information was protected and confidential. DHS Licensing Division told her that they would be investigating, and she helped set up interviews.[52]

29. DHS did not issue its final report until January 10, 2003. The Department concluded that both of the allegations of maltreatment were substantiated and that the Respondent was responsible for the maltreatment under the Vulnerable Adults Act (Minn. Stat. § 626.557).[53] The DHS did not allege that the Respondent had criminally assaulted M.R.[54]

30. The statute provides that DHS has 60 days to complete its investigation. If DHS does not complete the investigation within that time period, it is to notify the facility. There is no evidence that DHS ever advised the Respondent, the group home, or the guardian of the vulnerable adult that the investigation would not be completed in 60 days. However, the facility was aware that the investigation was on-going because the facility management person was interviewed in approximately March 2002. It is not unusual for DHS investigations to take more than 60 days or for DHS to fail to make all the notifications that are required by statute. Further, the inability of the lead agency to complete the final disposition within 60 calendar days does not invalidate the final disposition.[55]

31. Because there was more than one incident of substantiated maltreatment, the Department found that the maltreatment was recurring and the Respondent was disqualified from working in programs licensed by the Department of Human Services

and the Minnesota Department of Health, from facilities serving children or youth licensed by the Department of Corrections, and from unlicensed Personal Care Provider Organizations. The Commissioner of Human Services also found that the Respondent posed an imminent risk of harm to persons receiving services and must be immediately removed from a position allowing direct contact. By letter dated January 10, 2003, the Respondent was notified of the Department's determination and of his right to ask the Department to request reconsideration of the maltreatment determination and/or the disqualification.[56] He was also informed by letter dated March 4, 2003, of his right as a public employee under Minn. Stat. § 245A.04, subd. 3c, to a consolidated contested case hearing with respect to the maltreatment determinations and the disqualification.[57]

32. The Respondent requested reconsideration of both the maltreatment determinations and his disqualification. In his reconsideration request, the Respondent alleged that the allegations by Chrestomathy staff "are totally untrue and extremely exaggerated." He asserted that M.R. "was banging himself around the vehicle and was already exhausted when he arrived at the house, so of course he would be out of breath." He also contended that M.R.'s chest was not pinned against the back of the seat and pointed out that the seats are very close and there is only about 15 inches for him to get out of the van. He indicated that it was below freezing outside, another client was in the house, and M.R. needed to get in the house since he was naked and refused to put his clothes on. He also asserted that M.R. was not pulled from the van and did not fall to the floor and run into the house. He stated that M.R. can barely walk and needed to get on the floor himself to exit the vehicle. The Respondent alleged that the loud bang heard by Chrestomathy staff was M.R. banging his head on his own. The Respondent also asserted that "the day program is just retaliating against me and filing false reports." (Emphasis in original.) The Respondent asserted that he did not pose a risk of harm to those receiving services. He pointed out that M.R. is highly aggressive and self-injurious and asserted that M.R. suffered no harm because he was already banging his head and being abusive to himself. He denied that he had ever put any of his clients in harm and stated that he cares about the clients he cares for, had been a Human Services Technician for 13 years, and never has posed any risk of harm.[58]

33. Reconsideration requests are handled by the legal unit of DHS, which is a different unit than the one in which Mr. Janacek and Ms. Nass work.[59] With respect to reconsideration requests, the Department considers whether a preponderance of the evidence shows that maltreatment occurred, whether the information relied upon was correct, and whether the individual poses a risk of harm. After a recommendation was made by a staff attorney regarding the Respondent's reconsideration request,[60] Laura Plummer Zrust, the Legal Office Supervisor in the DHS Division of Licensing, conducted an independent review and made the final decision. She did not talk to the Respondent but merely conducted a record review. She decided that the information relied upon was correct and met the statutory definition of "recurring" maltreatment since there was more than one instance. She concluded that the maltreatment determination was correct, the conduct was not accidental or therapeutic, and the incidents could have reasonably been expected to produce pain or emotional distress, and that the determinations were supported by a preponderance of the evidence in that two direct witnesses provided consistent statements. Ms. Zrust also considered the eight factors

set forth in the statute and found that the Respondent did, in fact, pose a risk of harm. In Ms. Zrust's view, it was important that the Respondent's statement was not consistent with those of the other witnesses, he did not appear to accept responsibility for the incidents but merely alleged that they were false and fabricated, and he failed to recognize the impact on M.R. She did not find the Respondent's explanation to be credible. Accordingly, the Department did not reverse either of the maltreatment determinations or the disqualification.[61]

34. The Respondent thereafter requested a contested case hearing to seek review of the Department's maltreatment determinations and disqualification decision, resulting in the initiation of the present proceeding.

35. The Respondent had requested a transfer from the Burnsville group home before these incidents occurred, and elected to accept a transfer opportunity. Thus, he was not transferred by the facility based on the maltreatment allegations. The Respondent continued caring for vulnerable adults until he was disqualified. There is no evidence that there were any further complaints concerning the Respondent after February 2002.[62] There have been no substantiated allegations of maltreatment by the Respondent other than those involved in the present case.[63]

36. The Respondent worked at the MSOCS Donnelly group home located in Farmington from approximately February 26, 2002, to January 12, 2003. Very fragile developmentally disabled vulnerable adults reside at the Donnelly Facility. They are severely and profoundly mentally retarded and also physically disabled. They are confined to wheelchairs or beds and require total care. The residents at the Donnelly group home thus were even more vulnerable than those at the Burnsville group home. The Respondent worked on a regular basis at the Donnelly group home until the DHS decision was rendered.[64] Ms. Richert, the Respondent's supervisor, had no reason to believe that these individuals were at risk due to the Respondent working with them.[65]

37. The Respondent enjoyed doing activities with the residents at the Burnsville group home and was always willing to take the Burnsville residents on outings. He made some successful attempts to bring M.R. into the community. For example, the Respondent brought M.R. on rides, to his parents' lake home, and to his parents' restaurant on three occasions.[66]

38. M.R.'s relatives and the Human Services Technicians, Mental Retardation Residential Program Lead, and nurse with whom the Respondent has worked have never observed the Respondent mistreat or abuse any group home residents. They testified that the Respondent was friendly, caring, patient, involved, and active with the residents. They never observed the Respondent lose his temper with M.R. or other residents.[67]

39. Ms. Richert has known the Respondent since the 1980s. She supervised him approximately two years at Faribault Regional Treatment Center, during his employment in a group home in Bloomington, and during his employment at the Lakeville Intermediate Care Facility for the Mentally Retarded ("ICFMR"). During most of that time, the Respondent was a Human Services Technician. The Respondent was a good employee during the period that he was supervised by Ms. Richert. He worked in Lakeville with a person who was very behaviorally challenged prior to his employment

in the Burnsville group home. He had no prior problems with reports or concerns regarding the cares he provided to clients. He was in the process of establishing good rapport with M.R. at the time he transferred out of the Burnsville group home. Ms. Richert has never observed the Respondent engage in any behavior that she would even remotely characterize as maltreatment of a vulnerable adult.[68]

40. The Respondent had worked intermittently with M.R. while he was at the Faribault Treatment Center. M.R. had a good relationship with the Respondent and responded well to the Respondent.[69]

41. On April 24, 2003, the Department of Human Services served the Respondent with a Notice and Order for Hearing and Prehearing Conference.

42. On June 19, 2003, the Department served the Respondent with an Amended Notice of Hearing and Prehearing Conference specifying in further detail the statutory bases for the maltreatment findings and disqualification determination.

43. A Protective Order was entered in this matter on June 11, 2003, limiting the disclosure of not public data to parties, counsel, counsel's employees, and representatives of the parties to the extent necessary to prepare and present claims and defenses, and limiting the use of data emcompassed by the Order to this proceeding and not for any other purpose including collateral litigation without prior order of a district court. In addition, a Protective Order was entered during the hearing to protect the confidentiality of information relating to the original DHS investigator's employment.

44. These Findings are based on all of the evidence in the record. Citations to portions of the record are not intended to be exclusive references.

45. The Administrative Law Judge adopts as Findings any Conclusions that are more appropriately described as Findings.

Based upon these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner of Human Services have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 245A.04, subd. 3c, and 245A.08.

2. Proper notice of the hearing was timely given and all relevant substantive and procedural requirements of statutes and rules have been fulfilled.

3. Minn. Stat. § 245A.04, subd. 3d(a)(4) (2002),[70] provides that an individual shall be disqualified from any position allowing direct contact with persons receiving services from a program licensed by the Department if there has been a determination or disposition of substantiated serious or recurring maltreatment of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

4. Minn. Stat. § 245A.04, subd. 3b(b) (2002), specifies that, upon a request for reconsideration of a disqualification for recurring or serious maltreatment, the Commissioner must rescind the disqualification if the Commissioner finds that the information relied on to disqualify the individual is incorrect.

5. Minn. Stat. § 245A.04, subd. 3b(b) (2002), also provides that "[t]he commissioner may set aside the disqualification . . . if the commissioner finds that the individual does not pose a risk of harm to any person served by the applicant, license holder, or registrant under section 144A.71, subdivision 1." In determining whether or not an individual poses a risk of harm, the commissioner shall consider:

> the nature, severity, and consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the age and vulnerability of the victim at the time of the event, the harm suffered by the victim, the similarity between the victim and persons served by the program, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration.

The statute further specifies that, "[i]n reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder . . . over the interests of the license holder . . . ."

6. Minn. Stat. § 245A.04, subd. 3c(a) (2002), provides that, if a disqualification of a state employee was based on a maltreatment determination and was not set aside or rescinded by the Commissioner, the scope of the resulting contested case hearing shall include the maltreatment determination and the disqualification.

7. Under Minn. Stat. § 256.045, subd. 3b(a)(1) (2002), the Department has the burden of proving by a preponderance of the evidence that the Respondent is disqualified from being a license holder because he committed acts of maltreatment and those acts were serious or recurring. Under Minn. Stat. § 256.045, subd. 3b(b) (2002), the Department also has the burden of proving by a preponderance of the evidence that the Respondent poses a risk of harm to any person served by the program that employs him, and that his disqualification should not be set aside because he does pose such a risk.[71]

8. Minn. Stat. § 626.5572, subd. 2(b) defines "abuse" of a vulnerable adult to mean "[c]onduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following: (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult . . . ."

9. Minn. Stat. § 626.5572, subd. 3, defines "accident" to mean "a sudden, unforeseen, and unexpected occurrence or event which: (1) is not likely to occur and which could not have been prevented by exercise of due care; and (2) if occurring while a vulnerable adult is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event."

10. Minn. Stat. § 626.5572, subd. 20, defines "therapeutic conduct" to mean "the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver."

11. The Department did not prove by a preponderance of the evidence that the Respondent committed maltreatment in connection with the February 18, 2002, incident. The Department did prove by a preponderance of the evidence that the Respondent committed maltreatment in connection with the February 26, 2002, incident.

12. The Department did not prove by a preponderance of the evidence that the Respondent committed "recurring maltreatment" warranting disqualification.

13. The Administrative Law Judge adopts as Conclusions any Findings that are more appropriately described as Conclusions.

14. These Conclusions are reached for the reasons discussed in the attached Memorandum, which is hereby incorporated in these Conclusions by reference.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the Commissioner UPHOLD the determination that Eric Nelson committed maltreatment of a vulnerable adult on February 26, 2002, but RESCIND the determination that Mr. Nelson committed maltreatment of a vulnerable adult on February 18, 2002, as well as the disqualification issued to Mr. Nelson.

Dated: October 28, 2003

/s/ Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Tape recorded (8 tapes); no transcript prepared.

NOTICE

Pursuant to Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

Based upon a careful consideration of the entire record, the Administrative Law Judge recommends that the maltreatment determination be reversed as to the February 18, 2002, incident and affirmed as to the February 26, 2002, incident. Because there has not been recurring maltreatment, it is not appropriate to disqualify the Respondent from licensure. The reasons for this recommendation are detailed below.

Lisa Volk gave credible testimony at the hearing describing what happened on February 18, 2002. She persuasively denied having any knowledge of complaints by the Respondent or others at the Burnsville group home involving Chrestomathy and has no apparent motive to fabricate or exaggerate what happened. The essential details of her testimony were corroborated by Ms. Harper's documentation and interview with the original DHS investigator, as reported in Exhibit 1.[72] The Respondent's statement to the original DHS investigator that M.R. refused to get out of the van, was taking off his clothes, and was swinging his arms, and that he later exited the van without further incident, is not convincing in light of the consistent contrary version of events offered by Ms. Volk and Ms. Harper.[73]

Despite the fact that the Administrative Law Judge finds Ms. Volk's and Ms. Harper's statements to be credible concerning the February 18 incident, the Judge is not persuaded that the Department has shown by a preponderance of the evidence that the Respondent's conduct was, in fact, maltreatment. "Abuse" is defined to mean "[c]onduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress . . . ." In this instance, it appears that, after M.R. did not comply with verbal cues to leave the van, the Respondent placed at least one foot in the van,[74] leaned in, and extended his hand to M.R. M.R. then grabbed the Respondent's extended hand, and Respondent pulled M.R. to a standing position. According to Exhibit 1, Ms. Volk initially documented that it "looked and sounded like [M.R.] was having a hard time breathing" but later merely told the investigator during her interview that his "breathing sounded 'somewhat winded.'" She did not provide further explanation of what she meant by these comments during her testimony. Given the fact that M.R. had been engaging in target behaviors before the van arrived and M.R. was making a loud and aggressive "hooting" type of noise, it is equally likely that any winded breathing by the Respondent would be explained by his level of activity and agitation as by being pulled against the seat in front of him. Moreover, since M.R. was in a standing position and the Respondent was pulling M.R. at an angle against the seat in front of him rather than directlyforward against that seat, it seems unlikely that M.R. was, in fact, "pinned" against the back of the seat or that his chest was sufficiently compressed to have caused breathing difficulty.[75] Thus, the Judge concludes that the Department has not shown by a preponderance of the evidence that the Respondent's conduct in pulling M.R. briefly against the back of the seat produced or could reasonably be expected to produce physical pain or injury or emotional distress within the meaning of the statute.

Furthermore, the Department did not establish by a preponderance of the evidence that the Respondent's conduct on February 18 caused M.R. to fall. Neither Ms. Volk's statements and testimony nor Ms. Harper's statements established a clear causal connection between M.R.'s fall and the Respondent's conduct. Ms. Volk merely

indicated in her documentation and investigation interview that Respondent pulled M.R. against the back of the seat for about one minute. Then, according to Ms. Volk, M.R. fell to the floor of the van. During the hearing, she testified that M.R.'s feet "went out from under him." Similarly, Exhibit 1 indicates that Ms. Harper stated that M.R.'s legs "fell out" from under him after the Respondent pulled him. Given where Ms. Volk was standing and Ms. Harper was sitting at the time of the incident, M.R.'s lower body would have been blocked from their view, making it difficult for them to know precisely what caused him to end up on the floor. Moreover, there is no evidence that the Respondent released his hold on M.R., causing him to fall. In fact, Ms. Harper told the DHS investigator that the Respondent only released M.R. as he fell to the floor. It appears more likely that M.R. simply let go of the Respondent's hand and got down on the floor in order to scoot on his backside to the doorway of the van and exit, as was his custom. Accordingly, the Administrative Law Judge has recommended that the Commissioner rescind the maltreatment determination with respect to the February 18 incident.[76]

With respect to the February 26, 2002, incident, the Administrative Law Judge again finds the descriptions of the eye witnesses to be credible. Ms. Reed's hearing testimony was consistent with her prior statements to the DHS investigator as reported in Exhibit 1, and her account was corroborated by the information provided by Ms. Harper, as set forth in Exhibit 1. Ms. Reed, Ms. Harper, and the Respondent all agreed that M.R. took off all of his clothes, a blanket was requested by the Chrestomathy staff, the Respondent told them that he did not have a blanket, and the Respondent tried to coax M.R. out of the van and offered a snack as an inducement. Ms. Reed and Ms. Harper both stated that the Respondent became angry and pulled M.R. across the van seat, causing him to hit his head on the interior wall or window of the van and fall to the floor.[77] The Respondent's contention that he did not grab M.R.'s arms, pull him forcefully across the seat, or cause M.R. to fall and strike his head, as well as his later allegation during reconsideration that the noise heard by Ms. Reed and Ms. Harper was caused by M.R. injuring himself, are simply not convincing in light of the statements of the two witnesses to the contrary. In addition, such an approach would be consistent with the Respondent's testimony at the hearing that, as a general matter, if he were unable to get M.R. to leave the van by verbal prompts or bribing him with a snack, he would put his hand into the van so that M.R. would hopefully grab his hand and not hit him, and then pull M.R. out.

The Respondent had some good reasons for approaching the van on February 26 to provide assistance and undoubtedly was well-intentioned. The temperatures were below freezing outside, there was ice on the driveway (which M.R. did not handle well), and M.R. was totally nude in the van. The Respondent appropriately tried verbal cues and snack inducements before deciding that physical intervention was necessary. However, because the Respondent was the only staff person present at that time, another client who required supervision was inside the group home, and Chrestomathy staff were responsible for ensuring that M.R. disembarked from the van, it may not have been a wise choice for the Respondent to go out to the van. It also appears that the Respondent may have been less patient with M.R. under these conditions than he would otherwise have been. He could have provided a blanket to alleviate the concern about the cold and opted to wait for M.R. to exit the van, then help with the icy conditions. The Respondent's supervisor testified that, if M.R. was refusing to get out of

the van but was sitting quietly and was not freezing and was otherwise physically okay, that in general that would not be a situation for physical intervention. She advised first waiting to see what M.R. was going to do; then providing verbal prompting; then assessing danger and intervening if it was felt that he was going to injure other vulnerable adults or himself, or harm was going to come to him.

In any event, the Respondent's decision to physically intervene and the manner in which he carried out the intervention was not appropriate therapeutic conduct and was not consistent with the usual practice of other group home staff. The Respondent's approach was contrary to the procedure set forth in the transportation section of M.R.'s Consumer Support Plan, which simply advises care providers to intervene to protect others from harm, but otherwise, if aggression occurs, to come in the house, leave the doors open, and let M.R. come in on his own.[78] M.R. was simply sitting in the van with no other passengers. There is no evidence that he was posing a threat to anyone or to any property when the Respondent decided to provide physical assistance. Because the eye witnesses stated that the Respondent forcefully pulled M.R. across the van seat towards the door, causing him to fall off on the floor and strike his head, a preponderance of the evidence supports a finding that the Respondent engaged in conduct which produced or could reasonably be expected to produce physical pain or injury or emotional distress, and thereby engaged in conduct that fell within the statutory definition of "abuse" on February 26, 2002.

Finally, the Administrative Law Judge finds that the Respondent has not made a convincing showing that the Chrestomathy employees who reported the incidents were engaging in retaliation for the Respondent and other group home staff members making complaints about Chrestomathy's program. There was no evidence that Chrestomathy employees who witnessed the incidents had any knowledge of any complaints by Burnsville employees or any animosity toward the Respondent. There was no clear showing that Chrestomathy employees overheard any negative comments that may have been made by the Respondent or other staff concerning their handling of M.R. or their approach to getting M.R. to leave the van. Moreover, even though Ms. Schulz made similar comments and expressed similar concerns, no complaints were ever filed by Chrestomathy employees regarding her.

Accordingly, the Administrative Law Judge has recommended that the maltreatment determination be rescinded with respect to the February 19, 2002, incident and upheld with respect to the February 26, 2002, incident. Because the Respondent did not engage in recurring maltreatment, it is further recommended that the disqualification be rescinded.

B.L.N.

[1] Testimony of Nelson.
[2] Testimony of Nass, Richert, Nelson; Exs. 1 and 6.

[3] Testimony of Nass, Richert, Nelson.
[4] Testimony of Richert.
[5] Testimony of Nass, Richert, Nelson.
[6] Testimony of Richert, Schulz, Nelson.
[7] Testimony of The Respondent is considerably bigger and stronger than M.R. Testimony of Volk.
[8] Testimony of Richert, Schulz, Nelson, Nass, Reed, M.R.'s mother; Exs. 2 at 61-62, 3 at 70, 4 at 77-79.
[9] Testimony of Nass, Reed, Volk, Nelson.
[10] Testimony of Volk.
[11] Testimony of Reed.
[12] Testimony of Nelson.
[13] Testimony of Schulz, Kotek, Ruka.
[14] Testimony of Nelson.
[15] Testimony of Richert.
[16] Testimony of M.R.'s sister.
[17] Testimony of M.R.'s mother.
[18] Testimony of Nass, Schulz, Kotek, Nelson.
[19] Testimony of Reed, Volk.
[20] Testimony of Schulz, Volk.
[21] Ex. 3 at 73-74; Ex. 4 at 81; Testimony of Nass, Schulz, Kotek, Nelson.
[22] Testimony of Richert; Exs. 3, 4, 6, 7.
[23] Ex. 3 at 73-74.
[24] Ex. 4 at 77; Testimony of Richert, Schulz, Nelson, M.R.'s mother.
[25] Testimony of Richert, Schulz, Nelson.
[26] Testimony of Kotek.
[27] Testimony of Richert, Schulz, Nelson.
[28] Testimony of Richert.
[29] Exs. 2-4; Testimony of Nass, Richert, Reed.
[30] Testimony of Nass, Richert.
[31] Testimony of Richert, Schulz.
[32] Testimony of Schulz.
[33] Testimony of Richert.
[34] Testimony of Reed, Schulz.
[35] Testimony of Schulz.
[36]Testimony of Kotek.
[37] Testimony of Nelson.
[38] Testimony of Nelson.
[39] Based on her belief that there were five rows of bench seats in the van (rather than just four), Ms. Volk initially testified that M.R. was sitting in the fourth row on February 18, 2002. She may have intended to say that M.R. sat in the second from last (third) row. Ms. Volk also testified that M.R. usually sat in the third row of benches.
[40]Testimony of Volk, Schulz, Nelson; see Ex. 1.
[41] Testimony of Reed, Pritchard; Ex. 1. It was a cold day on February 26, 2002.
[42] Ms. Reed first described where M.R. was sitting as the second seat from the second door back on the driver's side, next to the window. Later she clarified that she sat where the note pad is pictured in Ex. 17, and M.R. sat behind her in the third seat back, near the window.
[43] Testimony of Reed; Ex. 1.
[44] Testimony of Nelson, Reed.
[45] Testimony of Reed, Nelson; Ex. 1.
[46] Testimony of Pritchard.
[47] Testimony of Nass.
[48] Testimony of Schulz.
[49] Testimony of Richert.
[50] Testimony of Nass, Volk, Reed, Schulz, Nelson, Ruka.
[51] Testimony of Janecek, Nass.
[52] Testimony of Richert.
[53] Exs. 1, 5; Testimony of Janecek, Nass.

[54] Testimony of Nass.
[55]Testimony of Janecek, Nass; Minn. Stat. § 626.557, subd. 9c(d).
[56] Ex. 5; Testimony of Janecek, Zrust.
[57] Ex. 11.
[58] Exs. 9, 11, 12.
[59] Testimony of Nass, Zrust.
[60] Testimony of Zrust; Ex. 13.
[61] Testimony of Zrust; Exs. 10, 14-15.
[62] Testimony of Janecek, Zrust.
[63] Testimony of Nelson.
[64] Testimony of Lohrmann, Richert, Nelson.
[65] Testimony of Richert.
[66] Testimony of Richert, Schulz, Kotek, Mother of M.R., Ruka, Nelson.
[67] Testimony of Schulz, Kotek, Lohrmann, Ruka, and Mother and Sister of M.R.,
[68] Testimony of Richert.
[69] Testimony of Kotek, Mother of M.R., Nelson.
[70]Minn. Stat. § 245A.04 was recodified in Chapter 245C effective April 18, 2003. There are, however, no substantive changes in the law. Testimony of Zrust.
[71] *Accord In the Matter of the Disqualification of Theresa Dorman*, OAH Docket No. 4-1800-15125-2 (2002); *In the Matter of the Disqualification of Peggy Jean Stone,* OAH Docket No. 12-1800-14286-2 (2001); *but see In the Matter of the Disqualification of Joyce Arlene Malgren*, OAH Docket No. 6-1800-14712-2 (2002) (once the Department presents a prima facie case that Ms. Malgren presented a risk of harm to the clients she wished to serve, Ms. Malgren must show by a preponderance of the evidence that she does not pose a risk of harm).
[72]Contrary to the Respondent's arguments, the relevant statutes do, in fact, permit the Commissioner to demonstrate reasonable cause for the action being proposed by submitting "statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule." Minn. Stat. 245A.08, subd. 3(a); see also Minn. Stat. §§ 245A.04, subd. 3c(b), 245A.07, subd. 3, and 626.557, subd. 9d(f). Accordingly, it is appropriate to take into consideration the information provided by non-testifying witnesses as set forth in Exhibit 1.
[73] At the hearing, the Respondent denied the information contained in Exhibit 1 but testified that he could no longer even recall working on February 18, 2002, or the incident described by the Chrestomathy employees. He testified that he could not recall pulling M.R. very forcefully that day or M.R. having a hard time breathing.
[74] As reflected in Exhibit 1, the Respondent admitted in connection with the February 26 incident that he "entered the day program van but remained in the 'step area' at the side door," thereby undermining his testimony at the hearing that he never entered the Chrestomathy van.
[75] There was some confusion at the hearing and in witness statements regarding the precise location in the van where M.R. was seated on February 18. The Respondent argued that it would not be possible for him to reach M.R. if M.R. was seated in the fourth row of benches(as asserted by Ms. Volk), the Respondent was standing in the van doorway with both feet on the pavement, and both of them had their arms fully extended. There was testimony that the distance from the back of the first seat in the van to the front of the fourth bench seat is eight feet. The Respondentprovided demonstrative exhibits attempting to show this. See Exs. 16-19. However, as noted above, Ms. Volk thought there were five rows of bench seats in the van when there are actually only four. She may have meant that M.R. sat in the second to last row, which would be the third row. In addition, the demonstration did not show the Respondent leaning into the van with one foot inside. Regardless of where M.R. was seated, it appears that the Respondent and M.R. were able to grasp each other's outstretched hands.
[76] Although the Administrative Law Judge does not find that this conduct rises to the level of maltreatment, it would have been preferable if the Respondent had adhered to the Transportation Procedure set forth in M.R.'s Consumer Support Plan (Ex. 3) and simply left the doors open for M.R. to get off the van and come in on his own.
[77] Ms. Harper told the DHS investigator that the Respondent remarked when he came back to the van to retrieve M.R.'s clothing that M.R. "already has brain damage so hitting [his] head would not have done more damage." Ms. Harper did not testify at the hearing. Because Ms. Reed presumably would have been in a position to hear this remark if it had been made but did not mention it during the DHS

investigation or her hearing testimony, no finding has been made regarding whether the Respondent made the alleged statement.

[78] Ex. 3 at DHS 74.